

1
FOR STATE
HEALTH DEPT.

Item 18 Film 251 11-1 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11797

11814

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH

a. COUNTY

St. Marys

MARYLAND

b. CITY OR TOWN (If outside corporate limits,
write RURAL and give nearest town)

Great Mills

c. LENGTH OF STAY IN 1b

Lill

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

October

24

19 59

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

Male

C.

WIDOWED

DIVORCED

12-22-23

9. AGE (In years
last birthday)

35

yrs.

IF UNDER 14
YEARS

Months

Days

IF UNDER 74 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Day Labor

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Francis Joseph Barber

14. MOTHER'S MAIDEN NAME

Mary Catherine Wahler

Address

Marie Peters 35 Cathedral St. Annapolis, Md

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

525X

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

INTERVAL BETWEEN
ONSET AND DEATH

Pulmonary Fibrosis

2
MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?
YES NO

Acute Alcoholism

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. While Not While
p.m. At work At work

20d. INJURY OCCURRED

2de. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

2df. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER

ACTUAL
SIGNATURE

CHARLES S. PETTY

DATE SIGNED

EXAMINER'S
NAME (Type)

Charles S. Petty

ASSISTANT MEDICAL EXAMINER

M.D.

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

10/25/59

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial 10/28/59

22c. NAME OF CEMETERY OR CREMATORIUM

Holy Face

22d. LOCATION (City, town, or country)

(State)

Great Mills,

Md.

23. FUNERAL DIRECTOR

W. Clarke Mattingley Leonardtown, Maryland

24a. REC'D BY REGISTRAR

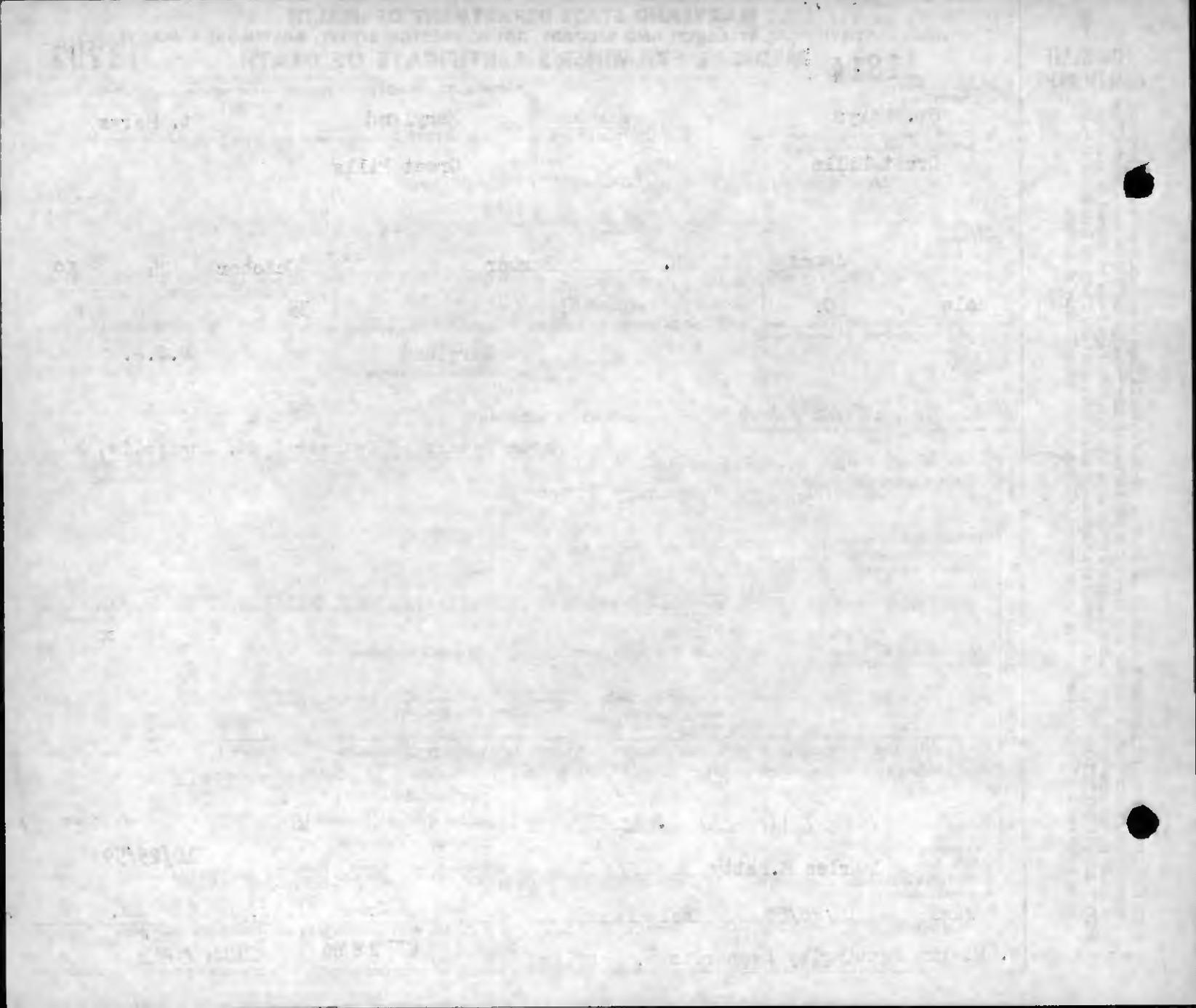
OCT 28 '59

24b. REGISTRAR'S SIGNATURE

Arthur S. Trahan

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any detail necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death.

VS. A15ME
5M 7/59



X

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PHA3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										Reg. Dist. No. 11798			
11815 MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY		St. Mary's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)		a. STATE Maryland		b. COUNTY St. Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Rural, Lexington Park		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Lexington Park					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2 mos.		d. STREET ADDRESS		513 Chinlee Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First George		Middle Francis		4. DATE OF DEATH		Month October		Day 22 Year 19 59			
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (in years last birthday)		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.	
Male		Caucasian		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Dec 30, 1925		33 yrs.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?				
Aviation Machinist			U.S. Navy			Massachusetts			USA				
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME							
George Francis Britt, Sr.						Unobtainable							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>If yes, give war or dates of service)</i>			16. SOCIAL SECURITY NO.			17. INFORMANT			Official U.S. Navy Records, Address				
Yes 1043 to 10-59			034-12-0508			USNAS, Patuxent River, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]													
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) TRAUMATIC INTRACRANIAL INJURY INTERVAL BETWEEN Minutes													
✓ 823X DUE TO Vital Center Depression,													
Conditions, if any, which gove rise to immediate cause (a), stating the underlying cause last. (b) Central Nervous System													
DUE TO (c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter full name in Part 1a Part 1b Part 1c Part 1d Part 1e Part 1f road Driver of auto at high rate of speed struck center/													
20c. TIME OF INJURY Month, Day, Year Hour <input checked="" type="checkbox"/> a.m. 11:00 Oct 22 1959			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hwy 235			20f. (City or town) Hermanville, St. Mary's, Md. (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>													
James P. Zettas, LT MC USNR, USNAS Patuxent River, Md. 10/22/59 ACTUAL SIGNATURE M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) WM D. BOYD, M.C. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>													
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORI		22d. LOCATION (City, town, or county)		(State)					
Burial		10/27/59				Northampton,		Mass.					
23. FUNERAL DIRECTOR'S SIGNATURE						ADDRESS							
W. Clarke Mattingley Leonardtown, Maryland						24a. REC'D BY REGISTRAR DATE OCT 28 '59							
						24b. REGISTRAR'S SIGNATURE							

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11816

CERTIFICATE OF DEATH

Reg. Dist. No.

11799

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY St. Marys		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia		b. COUNTY District of Columbia				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mechanicsville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d. STREET ADDRESS 4201 Mass. Ave. N.W.				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)		First Anna	Middle Knott	Last Easley	4. DATE OF DEATH 10 / 16 / 19 59	Month	Day	Year		
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH June 2 1882	9. AGE (In years lost birthday) 77 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Daniel Knott		14. MOTHER'S MAIDEN NAME Harriett Ann Dixon								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Martha Mower		Address 10602 TenBrook Dr. Silver Spring, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis INTERVAL BETWEEN ONSET AND DEATH 420.1 immediate DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardiovascular dis. DUE TO (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Mechanicsville		(County) Md.	(State) 10/16/59	
21. I certify that I attended the deceased from 10/16/59 , to 10/16/59 , 1959, that I last saw the deceased alive on 10/16/59 , 1959, and that death occurred at 940 M, from the causes and on the date stated above.									ADDRESS (Street, city or town, state) Mechanicsville, Md.	DATE SIGNED 10/16/59
ACTUAL SIGNATURE <i>J. Roy Guyther</i>		M.D.								
PHYSICIAN'S NAME (Type) J. Roy Guyther MD		Mechanicsville, Md.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/20/59		22c. NAME OF CEMETERY OR CREMATORIUM Rock Creek Cemetery		22d. LOCATION (City, town, or county) Washington, D. C.				
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co. Washington, D. C.		ADDRESS The S. H. Hines Co. Washington, D. C.		24a. REC'D BY REGISTRAR Arthur S. Hines		24b. REGISTRAR'S SIGNATURE Arthur S. Hines				
VS A15 (4) 15M 9/55				DATE OCT 19 '59						

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

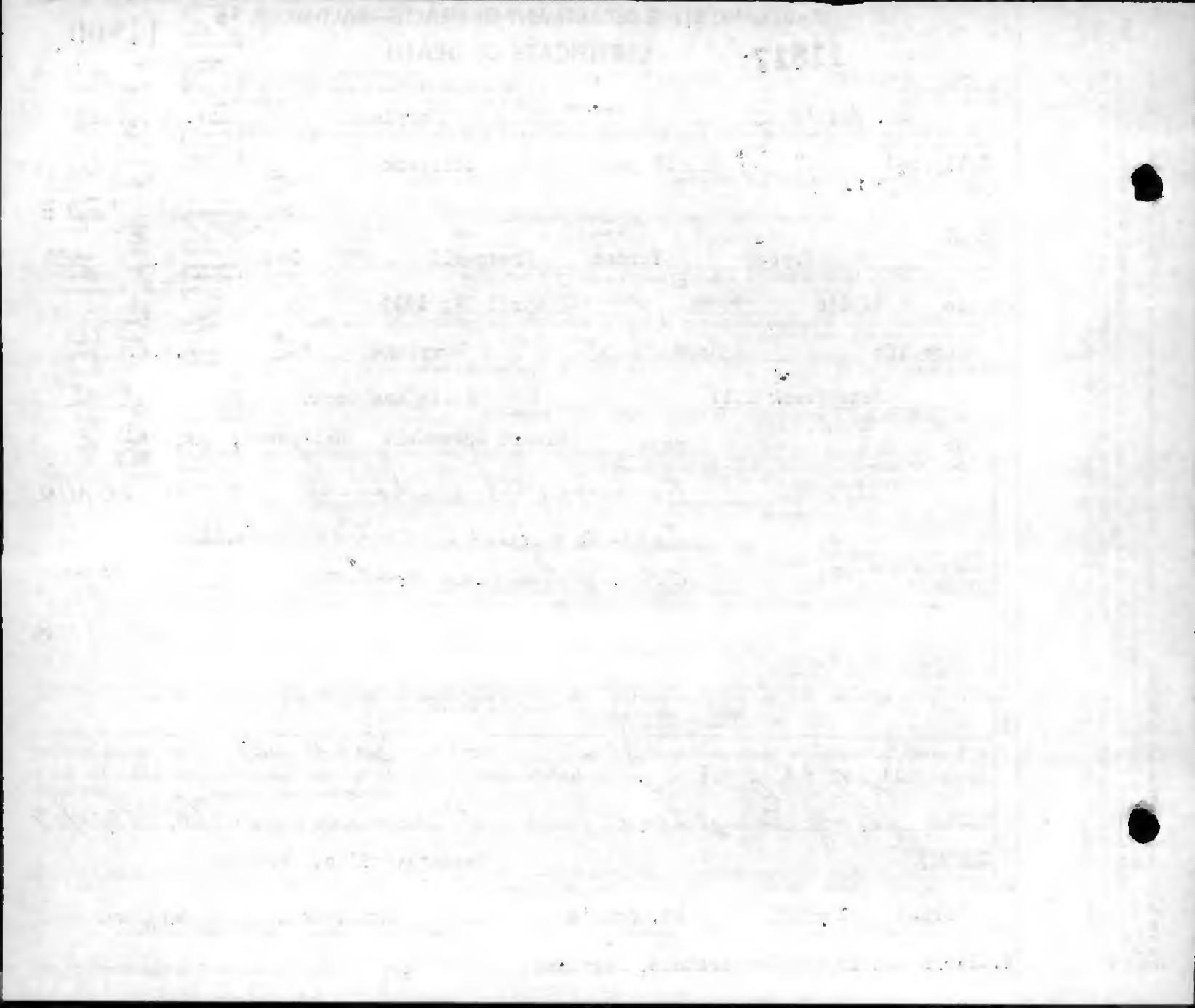
11817

CERTIFICATE OF DEATH

11800

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Mary's		2. USUAL RESIDENCE [Where deceased lived. If institution: Residence before admission] a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hollywood		c. LENGTH OF STAY IN 1b 18 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hollywood	
		f. STREET ADDRESS /	
g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Grace	Middle Teresa	Last Greenwell
4. DATE OF DEATH	Month October	Day 2	Year 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 24, 1916
9. AGE (In years last birthday) 43	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
13. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Frank Hill		14. MOTHER'S MAIDEN NAME Julia Ann Goode	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none	INFORMANT Albert Greenwell	Address Hollywood, Maryland
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I.—DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592 X DUE TO Conditions, if any, which give rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)			
Coronary Thrombosis Arteriosclerotic cardiovascular dis Chronic glomerular nephritis INTERVAL BETWEEN ONSET AND DEATH 20 min			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan , 1948, to Oct 2 , 1959, that I last saw the deceased alive on Sept 25 , 1959, and that death occurred at M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mechanicsville , 10/3/59			
ACTUAL SIGNATURE Roy E. Guther	M.D.	DATE SIGNED	
PHYSICIAN'S NAME (Type)	Mechanicsville, Maryland		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/5/59	22c. NAME OF CEMETERY OR CREMATORY St. John's	22d. LOCATION (City, town, or county) (State) Hollywood , Maryland
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley	ADDRESS Leonardtown, Maryland	24d. REC'D BY REGISTRAR DATE Oct 7 '59	24b. REGISTRAR'S SIGNATURE John S. Kline



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

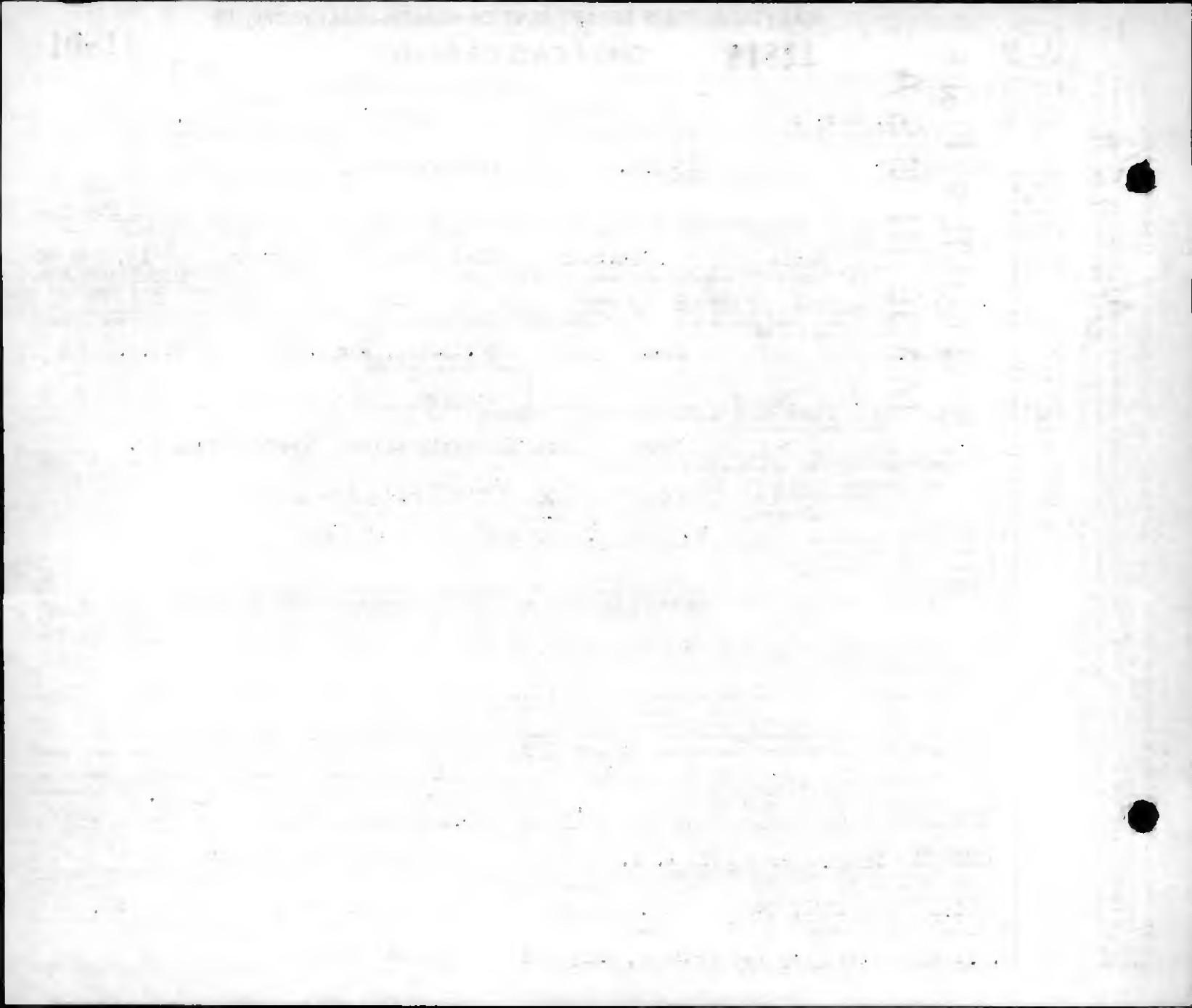
11818

CERTIFICATE OF DEATH

Reg. Dist. No.

11801

1. PLACE OF DEATH a. COUNTY St. Mary's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY St. Mary's					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		c. LENGTH OF STAY IN 1b 15 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Leonardtown		d. STREET ADDRESS /					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Mamie		First	Middle	Last	4. DATE OF DEATH 116t Holt	Month	Day	Year			
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		B. DATE OF BIRTH ? ? 1892	9. AGE (In years last birthday) 67	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Thomas				14. MOTHER'S MAIDEN NAME unknown							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT Mrs Elizabeth Miles		Address Leonardtown, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 33IX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH	
Cerebral Hemorrhage Hypertension - Diabetes											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Leonardtown		(County) 	(State) 		
21. I certify that I attended the deceased from Sept 20, 1959 , to Oct 13, 1959 , that I last saw the deceased alive on Sept 20, 1959 , and that death occurred at 5 A.M. from the causes and on the date stated above.										ADDRESS (Street, city or town, state) Leonardtown, Maryland	DATE SIGNED Charles Greenwell
ACTUAL SIGNATURE Charles Greenwell		M.D.									
PHYSICIAN'S NAME (Type) Charles Greenwell M. D.		Leonardtown, Maryland									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/17/59		22c. NAME OF CEMETERY OR CREMATORIUM St. Joseph		22d. LOCATION (City, town, or county) Morganza,		(State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Maryland		ADDRESS		24a. REC'D BY REGISTRAR OCT 21 '59		24b. REGISTRAR'S SIGNATURE Arthur S. ...					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11819

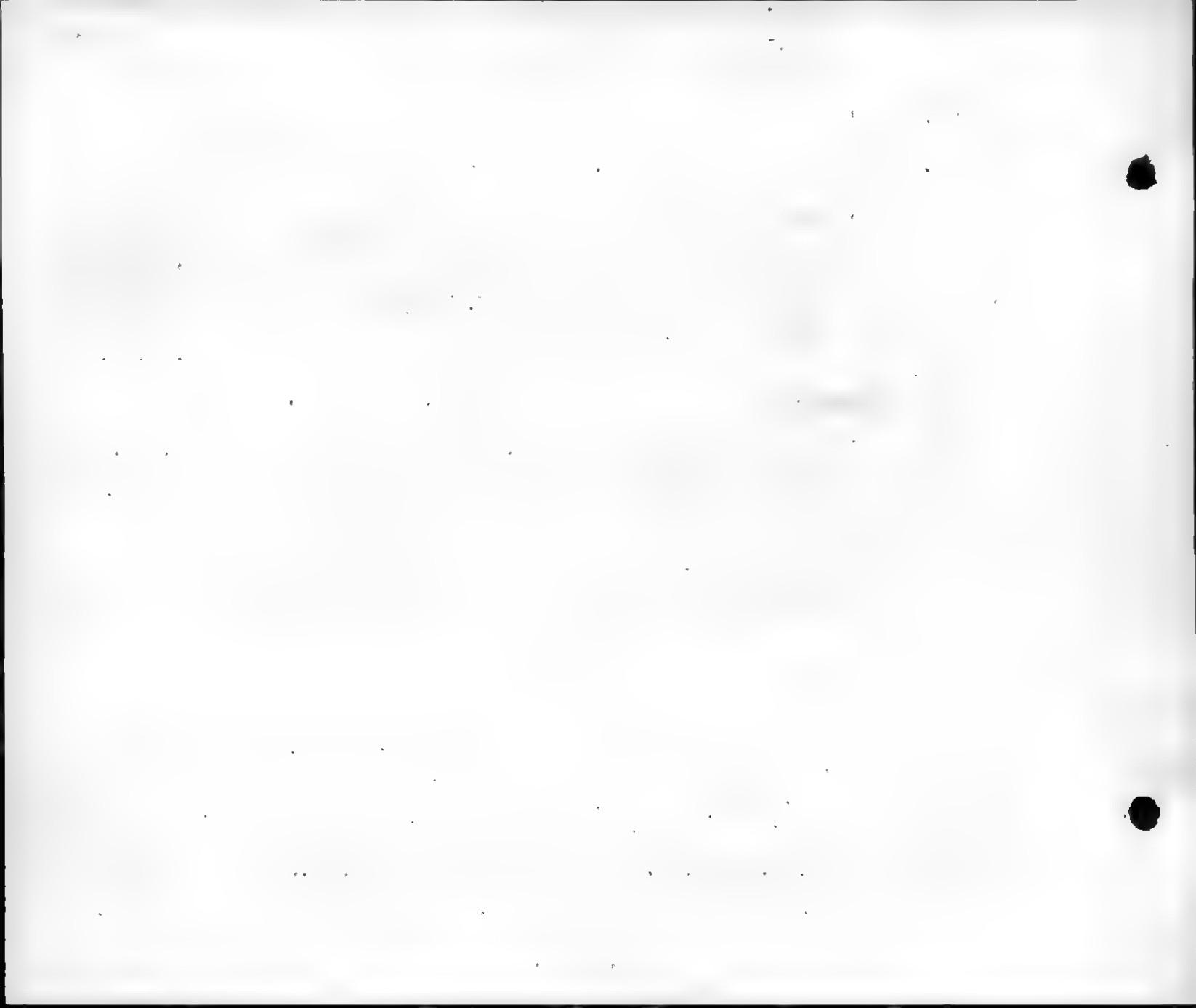
CERTIFICATE OF DEATH

11802

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY St. Mary's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		c. LENGTH OF STAY IN lb 16 da.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Chaptico			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital		d. STREET ADDRESS None		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Blanche	Middle F.	Last Jackson	4. DATE OF DEATH October 30, 1959	Month Year	Day	Year
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 27, 1873 xxxxx88xx88xx86	9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas Jenkins		14. MOTHER'S MAIDEN NAME Sarah Wilson		INFORMANT Mrs. Elmer Pilkerton, Chaptico, Md.		Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none		17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 446X DUE TO Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 6 months	
				PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 27, 1959, to Oct 30, 1959. That I last saw the deceased alive on Oct 27, 1959, and that death occurred at 1:12 PM, from the causes and on the date stated above.						ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE William D. Boyd, M. D.				M.D.		DATE SIGNED 10/30/59	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 2 Nov. 1959		22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cem.		22d. LOCATION (City, town, or county) Suitland, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home, Washington, D. C.		ADDRESS		24a. REC'D BY REGISTRAR NOV 6 '59 DATE		24b. REGISTRAR'S SIGNATURE Arthur J. Krause	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11803

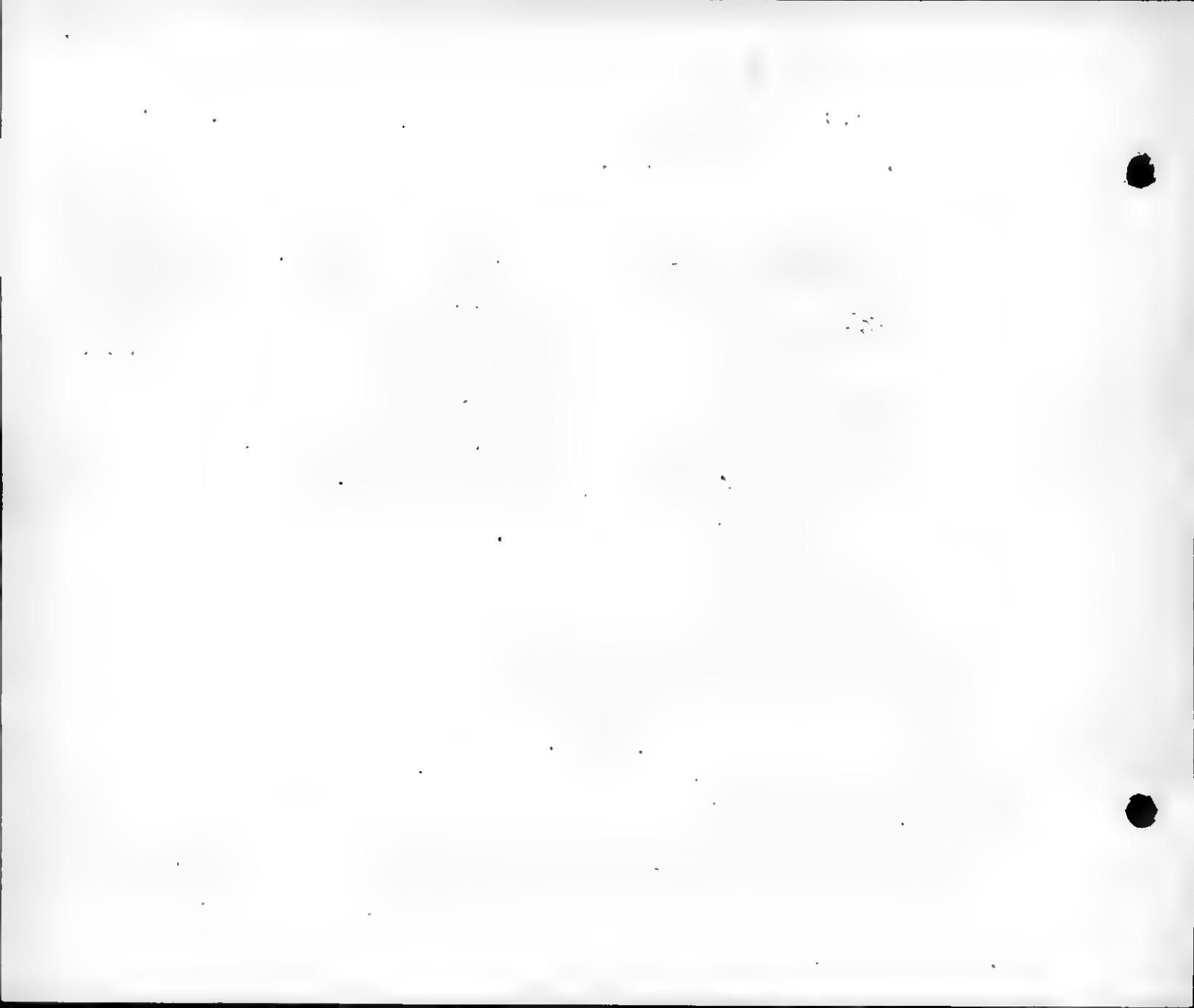
Reg. Dist. No.

11820

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY St. Mary's		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Oakley		c. LENGTH OF STAY IN lb 4 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Maria		Middle Ataway	Last Knott
4. DATE OF DEATH October 29, 1959		Month	Day
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Aug. 19, 1871		9. AGE (In years last birthday) 88 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. US JAIL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Maryland	
12 CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Leander Kn	
14. MOTHER'S MAIDEN NAME Dorothy M. Barber		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO none		INFORMANT Myrtle K. Hall	Address Oakley, Maryland
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4 w.o.d Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO CONGESTIVE HEART FAILURE Cerebral arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 1, 1958, to May 8, 1958, that I last saw the deceased alive on May 8, 1958, and that death occurred at 6 A.M. from the causes and on the date stated above ACTUAL SIGNATURE Leon W. Berube PHYSICIAN'S NAME (Type) Leon W. Berube 22. BURIAL, CREMATION, REMOVAL (Specify) Burial		ADDRESS Mechanicsville, Maryland 22d. LOCATION (City, town, or county) (State) Bushwood, Maryland	
22c. NAME OF CEMETERY OR CREMATORIUM Sacred Heart		24a. REC'D BY REGISTRAR DATE NOV 2 '59	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Maryland		24b. REGISTRAR'S SIGNATURE Arthur S. Thorne	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11821 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

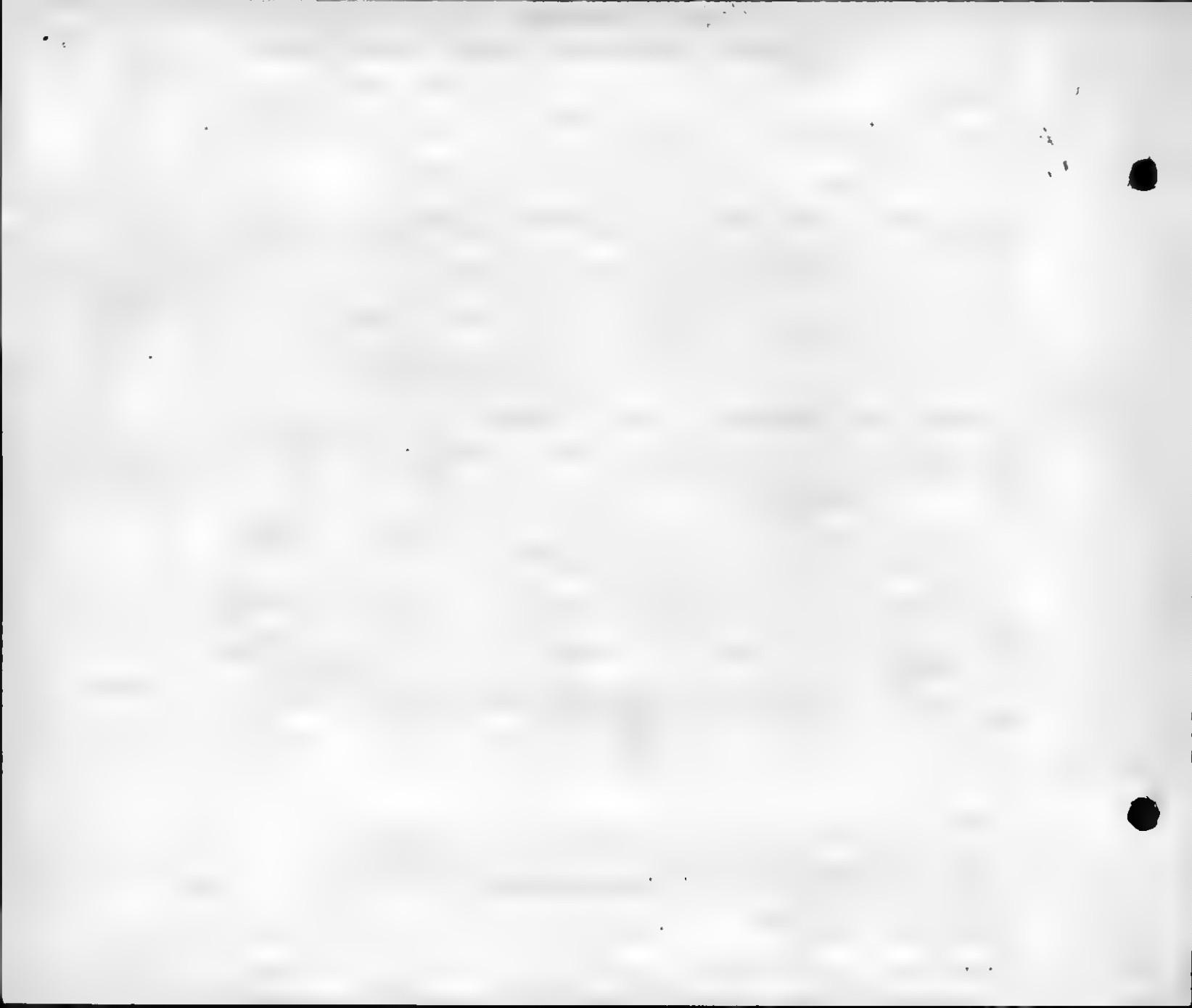
11804

Reg. Dist. No.

TO DEPUTY M. E. This certificate shall be executed within 24 hours after death. If any delay is necessary, please excuse the certifying officer. Write the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

1. PLACE OF DEATH a. COUNTY St. Mary's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY St. Mary's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		d. STREET ADDRESS		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First William	Middle Joseph	Last Lansdale	4. DATE OF DEATH October 19, 1959	Month October	Day 19	Year 1959
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH June 16, 1909	9. AGE (In years last birthday) 50 yrs.	10. UNDER 1 YEAR Months Days	11. UNDER 24 HRS Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME ? ?		14. MOTHER'S MAIDEN NAME ? ?						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. yes		17. INFORMANT Mrs Frances T. Lansdale Leonardtown, Maryland		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						INTERVAL BETWEEN ONSET AND DEATH 30 MIN		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 916.0		BURNS						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. { (b)		DUE TO						
{ (c)		DUE TO						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) The cause of the decease is a Coughiton fire						
20c. TIME OF INJURY Hour o. m. 1:30		Month, Day, Year 10-14 1959	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1401 S	20f. (City or town) Leonardtown	(County) Howard Co.	(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE 		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 10/20/59		
EXAMINER'S NAME (Type) William D. Boyd M. D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/21/59		22c. NAME OF CEMETERY OR CREMATORIUM St. Aloysius		22d. LOCATION (City, town, or county) Leonardtown, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE W.C. Mattingley Leonardtown, Maryland		ADDRESS		24a. REC'D BY REGISTRAR DATE OCT 26 '59		24b. REGISTRAR'S SIGNATURE Charles S. Mann		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										Reg. Dist. No. 11805								
11822 CERTIFICATE OF DEATH																		
1. PLACE OF DEATH D. COUNTY St. Mary's MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) D. STATE Maryland					b. COUNTY St. Mary's								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown			c. LENGTH OF STAY IN 1b 12 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Inigoes			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION																		
3. NAME OF DECEASED (Type or print)		First Marie		Middle 		Last Lee		4. DATE OF DEATH October 6, 1959		Month Day Year								
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 16, 1902		9. AGE (in years last birthday) 57 yrs		IF UNDER 1 YEAR Months Days Hours Min								
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.									
13. FATHER'S NAME Kemp Lee					14. MOTHER'S MAIDEN NAME Butler													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. No			INFORMANT none		Address Mary Edna Clayton St. Inigoes, Md.											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 6 mos								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1, 1957, to Oct 6, 1959, that I last saw the deceased alive on Oct 6, 1959, and that death occurred at 5 AM, from the causes and on the date stated above.										ADDRESS (Street, city or town, state) M.D. Lexington Park, Md.		DATE SIGNED 10-6-59						
ACTUAL SIGNATURE William H. Patrick M.D.		PHYSICIAN'S NAME (Type)								Lexington Park, Maryland								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/8/59		22c. NAME OF CEMETERY OR CREMATORIUM St. Peter Clavers			22d. LOCATION (City, town, or county) Ridge,		(State) Md.									
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Maryland					ADDRESS		24a. REC'D BY REGISTRAR DATE OCT 13 '59		24b. REGISTRAR'S SIGNATURE Charles L. Kline									



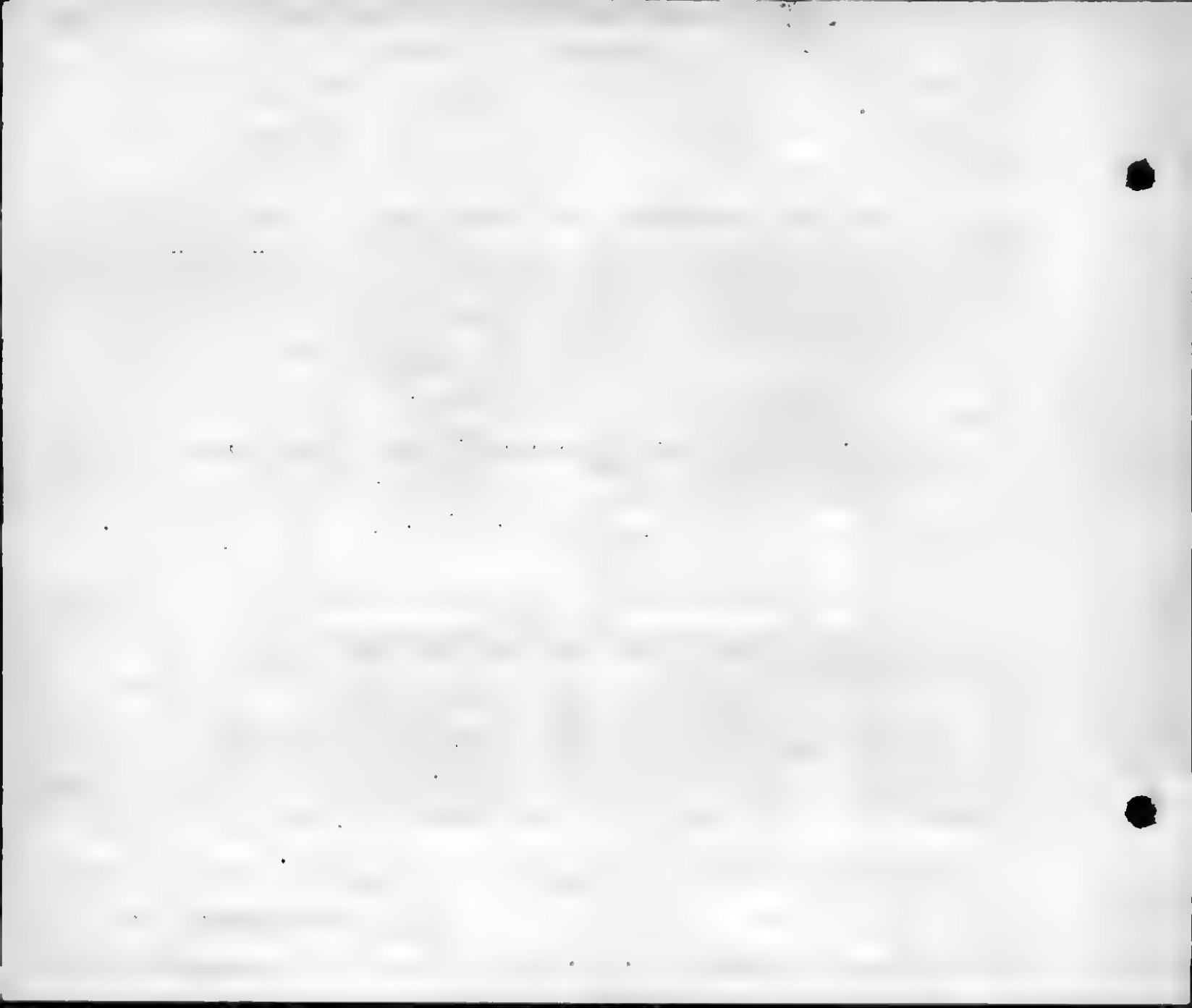
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11823 CERTIFICATE OF DEATH

11806

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Marys		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY St. Marys	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Drayden	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Marys Hospital		d. STREET ADDRESS Rural		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Henrietta	Middle Nan	Last Mac Donald	4. DATE OF DEATH 10 - 22 - 19 59	Month Day Year
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH June 29, 1884	9. AGE (In years lost birthday) 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 1 year
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Portland, Oregon	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Benjamin Southard		14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT H.J.C. MacDonald - Drayden, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 2 days			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Arteriosclerosis, Generalized.		DUE TO 10-15 yrs.			
(c)					
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 18 Oct , 19 59, to 22 Oct , 19 59, that I last saw the deceased alive on 26 Oct , 19 59, and that death occurred at 2: A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED					
ACTUAL SIGNATURE Ernest D. Rehm		M.D. Leonardtown, Md. 10/22/59			
PHYSICIAN'S NAME (Type) Ernest Rehm, MD		Leonardtown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 10/22/59		22c. NAME OF CEMETERY OR CREMATORIUM J.Wm. Lee	
22d. LOCATION (City, town, or county) Washington, D.C.					
23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE OCT 26 '59	
				24b. REGISTRAR'S SIGNATURE 26-874	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 4 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for our files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V.S. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11824 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11807

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission)		
St. Marys				a. STATE Maryland b. COUNTY St. Marys		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
Lexington Park				X Lexington Park		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		STREET ADDRESS		e. IS RESIDENT ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Rural		Rural				
3. NAME OF DECEASED (Type or print)		First	Middle	Lost	4. DATE OF DEATH	
Wallace		M.	Morehead		10/ 28 / 19 59	
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday) 44 yrs.	
M		W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	1/9/1915	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		
Electrical Mechanic		Civil Service		West Virginia		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?		
George H. Morehead		Betty Farquharson		USA		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (For no. or unknown)		16. SOCIAL SECURITY NO.		Address		
Yes		WV 2				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary occlusion 20 min				
420.1 DUE TO						
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost.						
DUE TO						
(c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
19						
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED
EXAMINER'S NAME (Type)		Wm. D. Boyd, MD				10/30/59
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) (State)
Burial		11/2/59		Arlington National		Arlington, Va.
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE
P.B. Robinson - Leonardtown, Md.				NOV 4 '59		C. B. G. Times



MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

11898

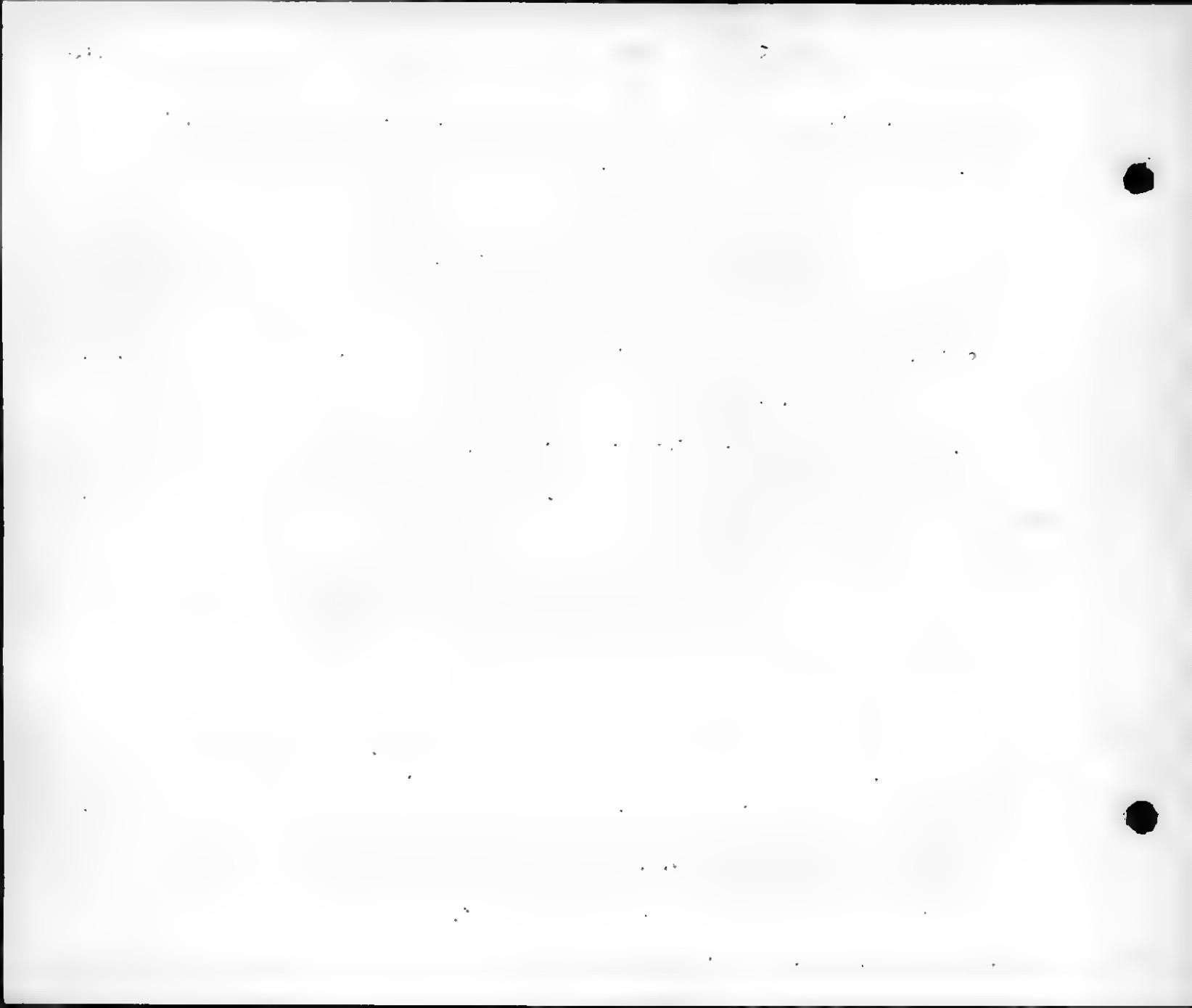
11825

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours of death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY St. Mary's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived - If institution, residence before admission) a. STATE Maryland		b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Compton		c. LENGTH OF STAY IN lb 14 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Compton		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Samuel	Middle Francis	Last Perkins Jr.	4. DATE OF DEATH	Month October	Day 26	Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1906	9. AGE (In years last birthday) 53 yrs	IF UNDER 1 YEAR Months 53	IF UNDER 24 HRS Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Commercial Artist		10b. KIND OF BUSINESS OR INDUSTRY 577 10 6076		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Samuel F. Perkins				14. MOTHER'S MAIDEN NAME Effie Garcia			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 577 10 6076		INFORMANT Loretta D. Perkins		Address Compton, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Sclerosis 34 SX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 6, 1953, to Oct. 26, 1959, that I last saw the deceased alive on Oct. 25, 1959, and that death occurred at 4 A. M. from the causes and on the date stated above							
ACTUAL SIGNATURE <i>Wm D Boyd</i>		M.D.		ADDRESS (Street, city or town, state) Leonardtown, Maryland		DATE SIGNED 10/26/59	
PHYSICIAN'S NAME (Type) William D. Boyd M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 10/28/59	22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery		22d. LOCATION (City, town, or county) Washington, D. C.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Maryland		ADDRESS		24a. REC'D BY REGISTRAR OCT 28 '59	24b. REGISTRAR'S SIGNATURE <i>Clinton S. Thomas</i>		

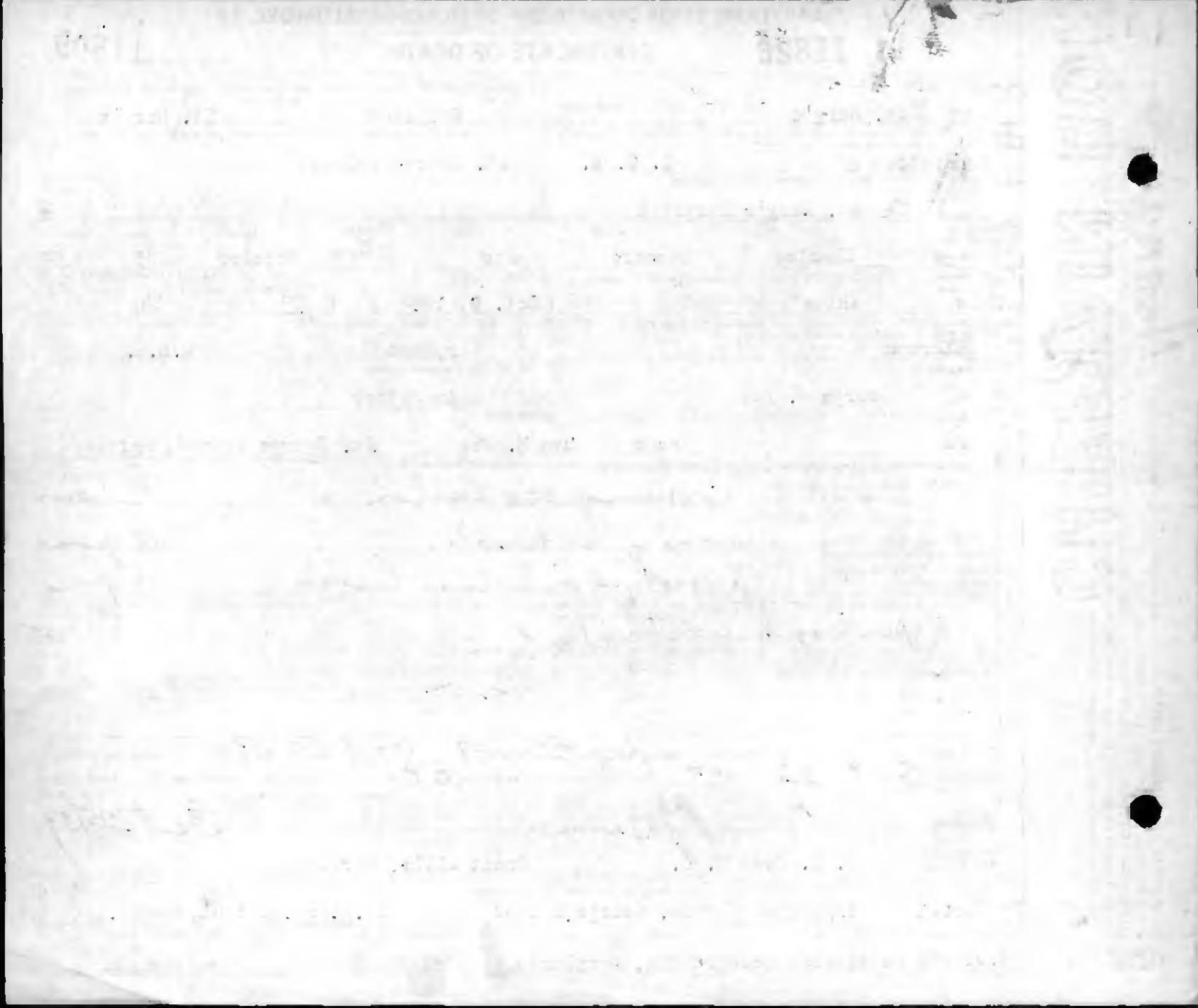


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11826 CERTIFICATE OF DEATH

Reg. Dist. No. **11809**

1. PLACE OF DEATH a. COUNTY St. Mary's		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		c. LENGTH OF STAY IN 1b D. O. A.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Charles	Middle Leonard	Last Poe
4. DATE OF DEATH	Month October	Day 23	Year 19 59
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 9, 1884
9. AGE (In years last birthday) 75 yrs.	10. IF UNDER 1 YEAR Months 14	11. IF UNDER 24 HRS. Days 14	12. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watermen	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME George W. Poe	14. MOTHER'S MAIDEN NAME Mamie Potter		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. none	INFORMANT Eva M. Poe	Address St. George Island, Maryland
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary occlusion INTERVAL BETWEEN ONSET AND DEATH 12 hour			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary sclerosis 10 years (c) Generalized arteriosclerosis 15 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertrophic arthritis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from September 1949 to Oct 25, 1959 , that I last saw the deceased alive on Oct 23, 1959 , and that death occurred at 07 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>P. J. Bean</i>	ADDRESS (Street, city or town, state) Great Mills, Maryland DATE SIGNED <i>Oct 25/59</i>		
PHYSICIAN'S NAME (Type) P. J. Bean M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/26/59	22c. NAME OF CEMETERY OR CREMATORIUM St. George Island	22d. LOCATION (City, town, or county) (State) St. George Island, Md.
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Maryland	ADDRESS	24a. REC'D BY REGISTRAR NOV 2 '59	24b. REGISTRAR'S SIGNATURE <i>Charles S. Evans</i>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11827 CERTIFICATE OF DEATH

11810

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Mary's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Avenue		c. LENGTH OF STAY IN lb 12 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Avenue		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First Alys	Middle Marie	Last Young	4. DATE OF DEATH Month October	Day 2,	Year 1959
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> March 13, 1912	9. AGE (In years last birthday) 47 yrs.	IF UNDER 1 YEAR Months 47	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Washington, D.C.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13. FATHER'S NAME Howard A. Houser	14. MOTHER'S MAIDEN NAME Virginia McWhorter
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	INFORMANT Edward S. Young	Address Avenue, Maryland
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 155.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		<i>Carcinomatosis</i> <i>Carcinoma of the gall Bladder</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		
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20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Leonardtown</i>	(County) <i>Md.</i>	(State) <i>Md.</i>
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21. I certify that I attended the deceased from 3 months alive on 19. 1. 59 , and that death occurred at home on 21. 1. 59 . That I last saw the deceased on the causes and on the date stated above.	ADDRESS (Street, city or town, state) <i>Leonardtown Md.</i>	DATE SIGNED <i>Leonardtown Md.</i>
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ACTUAL SIGNATURE <i>J. Vassar</i>	PHYSICIAN'S NAME (Type) <i>Leonardtown Md.</i>
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22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/5/59	22c. NAME OF CEMETERY OR CREMATORIUM All Saints	22d. LOCATION (City, town, or county) Oakley,	(State) Md.
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23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley	ADDRESS Leonardtown, Maryland	24a. REC'D BY REGISTRAR Arthur S. Kline	24b. REGISTRAR'S SIGNATURE Arthur S. Kline
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